

The Hampden Hippocrat

A Bulletin for the Hampden District of the Massachusetts Medical Society

VOLUME XV

MARCH, 1959

NO. 3



SHRINERS' HOSPITAL FOR CRIPPLED CHILDREN

(For New Construction, See Page 18.)



In this issue: "INTANGIBLES in the
TREATMENT of TRAUMA"
by Dr. McLaughlin.

Hampden District Medical Society

Founded 1840

OFFICERS

<i>President</i>	Thomas F. Reilly, M. D.
<i>Vice President</i>	John A. Burke, M. D.
<i>Secretary</i>	Harry N. Memery, M. D.
<i>Treasurer</i>	Howard B. Brown, M. D.
<i>Assistant to the Secretary</i>	Ray T. Smith, M. D.

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Harry N. Memery, M. D.	<i>ex-officio</i>	Howard B. Brown, M. D.
Robert G. Ernst, M. D.	1959	Leroy J. Kendrew, M. D.
Azel P. Barney, M. D.	1960	Eugene W. Beauchamp, M. D.
Henry Burkhardt, M. D.	1961	Samuel Klibanoff, M. D.

Chairmen of Standing Committees

<i>Public Relations</i>	Joseph M. Baker, M. D.
<i>Legislative</i>	Theodore R. Miner, M. D.
<i>Woman's Auxiliary</i>	Azel P. Barney, M. D.
<i>Public Health</i>	Norman A. Pokorny, M. D.
<i>Insurance, Labor Relations and Industrial Accidents</i>	Eugene W. Beauchamp, M. D.
<i>Malpractice and Medico-Legal Affairs</i>	Wayne C. Barnes, M. D.
<i>Nominating</i>	Edward P. Bagge, M. D.

Chairmen of Special Committees

<i>Medical Advisory</i>	Noah N. Feldman, M. D.
<i>Blue Shield District Professional Service</i>	M. Gene Black, M. D.
<i>Emergency Medical Service</i>	Peter Zarecki, M. D.
<i>Health and Accident Insurance</i>	William J. Cosgriff, M. D.
<i>Mental Health</i>	Olive A. Cooper, M. D.
<i>Rehabilitation</i>	Joseph P. Derby, M. D.
<i>Representatives on Community Council</i>	Allen S. Johnson, M. D. and Thomas F. Reilly, M. D.

The Hampden Hippocrat

"Life is short and art is long, the occasion fleeting, experience fallacious and judgment difficult."

Hippocrates

Published monthly except July and August

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VOLUME XV

MARCH, 1959

No. 3

EDITORIALS

"OPERATION COCONUT"

On December 6, 1958, the first practical test of the disaster plans of the three general hospitals in Springfield was carried out. The plans of the Mercy, Wesson Memorial and Springfield Hospitals have been carefully worked out in detail by the disaster committees of these hospitals.

Approximately one hundred high school students were tagged in trains in the railroad yards at Charles and Chestnut Streets.

At a pre-arranged time, 0900, twenty assorted vehicles reported to an ambulance pool near the "disaster area". A dozen trained first aid workers and twenty-four public health nurses went to the scene under the supervision of physicians pre-assigned to first aid teams.

By the use of two-way portable short wave radio units strategically spotted, ambulances were controlled and dis-

patched to the various hospitals.

Each hospital used its own two-way short wave radio for coordination of its activities with Springfield Civil Defense "Disaster Control Center". These recently acquired radios contributed a great deal to this success and effectiveness of this exercise.

By the use of data regarding bed space and ambulatory cases reported daily to the Springfield Civil Defense headquarters, distribution of casualties to local hospitals was facilitated.

At a "critique" held after this maneuver, it was the consensus of all concerned that many helpful ideas had been gained by such a "dry run". One very excellent suggestion came from the Red Cross to establish a central registration point for all casualties. This will be established by the local chapter of the Red Cross with the co-operation of each hospital. Casualties

will be promptly reported to this central registration office to help the public locate injured ones.

"*Operation Coconut*" is a code name used by the medical division of the Springfield Civil Defense Agency to cover situations caused by fires (such as the Coconut Grove fire), explosions, train wrecks and other local disasters involving enough casualties to mobilize hospital disaster teams.

Should the need for our mobilization of medical resources arise "Operation Coconut" announced over TV or radio will indicate to you that you should report to your disaster assignment. Frequent re-evaluation of methods and plans are necessary to insure prompt, competent, medical care in times of disaster.

THE FORWARD LOOK

Yale's unique Professor William Summer devoted his life to delving in the dust of centuries to trace 'Man's Rough Road' since time began. From his findings he drew fixed conclusions that he recommended for guidance of human progress. Men in general, doctors especially, should learn from their mistakes. Splendid advice it is that should become the rule. But it would be foolish to confine our thinking entirely to what has gone before. We need prophets and thinkers who can penetrate the mists of the future in order to find trustworthy paths for us to follow as we evolve.

We who have lived through the first half of the twentieth century know full well that this turbulent world is in a state of flux. The old order is passing in many fields, social, economic, and political,—even the climate seems unsettled. Not the least of the upheavals is the change in the practice of medicine. Patients no longer can be considered the private property of the family physician who used to run in so frequently for a five minute chat and a look at the tongue. Pharmacists today have small need to puzzle over multiform prescriptions that had to work one way or another,—Pike's peak or bust, no half-way stations.

Some of our more thoughtful fellows are casting about in their minds for more satisfactory methods of practicing medicine in days to come. Somehow they would like to retain the direct approach and at the same time to avoid the impersonal nature of beaurocratic medicine. They would perhaps band congenial practitioners together to apportion the work in appropriate sections, and arrange schedules so as to cover the twenty-four hours, holidays and time off, and to share overhead expenses.

Let us have these dreams and figments from you thinkers who can solidify them sufficiently to permit transmission through the Hippocrat,—or are you thoughtless enough to allow the social planners to do the thinking for you? Baggs

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FINAL REMINDER

ATTENTION COMMITTEE CHAIRMEN!

In order to shorten the coming Annual Meeting the Executive Committee recently voted that not all annual reports need be presented at that meeting.

Reports which are purely informational in character may instead be published in the Hippocrat. The only two requirements are; (1) that the report not exceed the maximum of 300 words, and (2) that the report reach the desk of the Editor-in-Chief not later than March 20.

These reports will appear in the April issue of the Hippocrat prior to the Annual Meeting, which is scheduled to take place on April 28.

Reports containing "recommendations" will still have to be presented at the Annual Meeting.

Chairmen of sub-committees will not present reports at the Annual Meeting. They will report instead to their respective Parent Committees.

Your co-operation is urgently requested.

Harry N. Memery, Secretary

FINAL REMINDER

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PEN-KARES—Scored, compressed, uncoated tablets for oral administration.

Each tablet contains 200,000 units of crystalline Penicillin G potassium, buffered with calcium carbonate.

CONCLUSION: A tried and proven antibiotic that cost your patient about 10¢ each.

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President's Page



WHAT EVERY LAYMAN SHOULD KNOW

Many laymen are under the impression that physicians are a highly privileged and pampered lot. They see one or two Caduceus-trimmed Cadillacs and conclude that all doctors live in the lap of luxury. Only a little while ago a labor leader in this area expressed the fantastic belief that "... all doctors make enough money within fifteen years as to become independently wealthy and ready to retire".

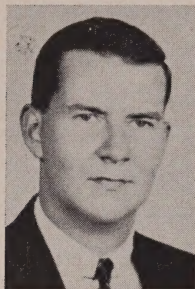
To become a full-fledged, well-qualified physician, as we all know, takes many years of rigorous training in schools and in hospitals. It takes also many thousands of dollars, as the family of any medical student only too well knows. Nevertheless the physician's total lifetime income is meager by comparison with that of much less demanding trades and occupations. Whereas the plumber begins to collect his weekly pay while still in his 'teens, the doctor rarely sees a penny before he has reached his 30th birthday. Furthermore, the doctor's earnings have lagged far behind the rising cost of other commodities. Since 1940, as Dr. Allen Johnson pointed out at the last Special Meeting, the consumer index doubled, hospital cost quadrupled but the doctor's fees increased only 75%.

We now learn from a recent survey by Parke Davis & Co. that doctors have less leisure, that they take fewer vacations and that they are vulnerable to a long list of occupational hazards (infections, allergies, auto accidents, radiation, etc.). We learn also that they work much longer hours than the average person. To this should be added the many hours we spend at hospital and medical meetings, conventions, and post-graduate courses. What should be added also are the hours devoted without remuneration to ward work, to teaching and to research. And finally, it should be emphasized that our day's work is seldom done. Long after the layman has cast the cares of his day's work aside the doctor forever remains at the mercy of the telephone which may at any time interrupt his belated dinner, his abbreviated night's sleep or his rare evening at the movies.

These facts are generally known to most physicians, but what about the laity? Who is to inform and enlighten the public? The press, radio and television, if we are to judge by past experience, apparently are not inclined in that direction. The task therefore is our own. It is up to us to call attention to the facts that the doctor's life is far from being a bed of roses, that he works hard, and that his financial rewards have lagged far behind the rest of our national economy.

T. F. Reilly, M.D.

NEW MEMBERS



William M. Donnelly, Jr., M. D.

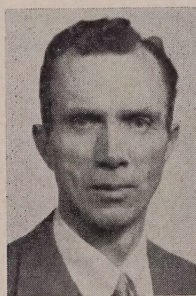
Office: 162 Suffolk Street, Holyoke, Mass.

Medical School:

New York Medical College-Flower-
Fifth Avenue Hospital - 1957
New York, New York

Internship: Mercy Hospital - 1957-1958
Springfield, Mass.

Specialty: General Practice



Isak O. Meshulam, M. D.

Office: 458 Grattan Street, Chicopee, Mass.

Born: October 29, 1916 - Edirne, Turkey

Medical School:

Istanbul Medical School - 1942
Istanbul, Turkey

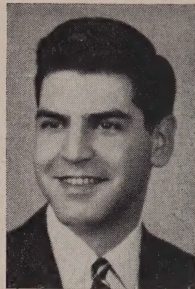
Internship:

Wesson Memorial Hospital - 1955-1956

Residencies:

Seton Hospital - 1953, Bronx, New York
Springfield Hospital - 1954-1955

Specialty: General Practice



Manuel J. Soares, M. D.

Office: 19 Holbrook Street, Palmer, Mass.

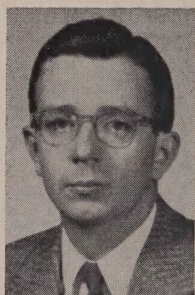
Born: August 16, 1931 - Hartford, Conn.

Medical School:

New York College-Flower-
Fifth Avenue Hospital - 1957
New York, New York

Internship: Mercy Hospital - 1957-1958
Springfield, Mass.

Specialty: General Practice



Stanley N. Teale, M. D.

Office: 10 Chestnut Street, Springfield, Mass

Born: July 1, 1921 - Waterville, Quebec, Can.

Medical School:

Dalhousie University, School of Medicine -
1949, Halifax, Nova Scotia, Canada, Rotating

Residencies:

Springfield Hospital - 1949-1950
New England Center Hospital - 1950-1951
and 1957-1958

Specialty: Internal Medicine

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AUXILIARY DOINGS

The February meeting of the Woman's Auxiliary was held at the Weston Maternity Hospital. The excellent attendance at 9:30 A. M. warrants the inclusion of at least one morning meeting in the program for next year.

Dean William Cheney of Springfield College graciously substituted as speaker for Mrs. Abraham Pinanski who was forced to cancel her engagement due to illness. Dean Cheney's subject was "The Newer Trends in Scholarships". His remarks were particularly interesting at this time as the Auxiliary's Scholarship program is being undertaken.

At the business meeting the proceeds of the White Cap Ball were reported by Mrs. Harry Baker at \$1551. This will provide the funds for 12 grants for nurses in training in Hampden District. Mrs. Aloysius Bloniarz announced the deadline date for applications as May 1st.

Mrs. Edward Halton and Mrs. Azel Barney reported that plans are under way for three Hospital tours to which counselors and students of the High Schools in Hampden District are invited. The film "Helping Hands for Julie" will be shown. This excellent film is one of the services of the A.M.A., the A.H.A. and Squibb and is designed to attract students into fields allied to medicine. The "helping hands" aiding the family doctor, the

surgeon, and the resident in their work with "Julie" are those of nurses, medical technologist, X-ray technician, the medical record librarian, the dietitian and the physical therapist. The dates of the tours are for the Holyoke Hospital, March 18th; the Mercy Hospital, March 31st; the Providence Hospital, April 1.

New members of the Auxiliary, introduced by Mrs. Edwin Gillis, are: Mrs. William Donnelly, Mrs. J. C. Hall, Mrs. Bennett Barton, Mrs. William Whittlesey, Mrs. M. J. Soares, Mrs. Alonzo Sheffield, Jr., Mrs. Richard Douglas, Mrs. Bernard Wantman and Mrs. B. Lincoln Wales, Jr.

Mrs. J. W. S. Hartshorn, Jr., Legislative Chairman, led a discussion on the Chiropractic licensing bill and distributed the addresses of Senators and Representatives with whom individuals were urged to register opposition.

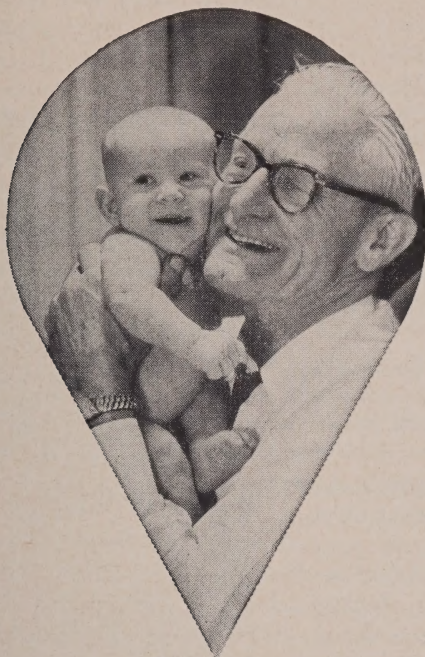
Mrs. Arthur Gramse, president-elect, concluded the business meeting with a review of the recent meetings in Boston of the State Auxiliary's Executive Board at which she presented the semi-annual report for Hampden District.

The next session of the Auxiliary will be its Annual meeting to be held April 14, 1959 at 12:30 P. M. at the Crestview Country Club.

Mrs. Elmer F. Franseen, President Woman's Auxiliary to the Hampden District Medical Society



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CORRESPONDENCE

Polio Reminder

Dear Hippocrat:

I want to call your attention to a resolution adopted by our House of Delegates at its recent meeting in Minneapolis. In my opinion it is extremely important. It directly concerns your society. It is about polio inoculation.

On the recommendation of the Board of Trustees the House called upon

each physician to assume the responsibility for making certain whenever possible that all members of families he serves receive protection against poliomyelitis by having the full three doses of polio vaccine.

state medical organizations to arrange with state health departments for a joint effort to bring together county medical societies and county health department representatives to form study committees to survey the local inoculation problem and work together to solve it.

county medical societies to meet with local health departments to create study committees to survey the immunization problem and work out a program to meet it.

Fifty-four per cent of our population under 40 have not completed their inoculation series. This is far short of our original goal of vaccination of all

persons under 40. I hope you will make every effort this spring to follow the suggestions of the House of Delegates.

Gunnar Gundersen, M. D.
President, AMA

Hypnosis

Dear Hippocrat:

On Wednesday, April 1, 1959, the Valley District Dental Society has invited Dr. Philip Ament of Buffalo, N. Y. to lecture on Hypnosis from 2 P. M. to 4 P. M.

In addition to the lecture there will be two moving pictures, one on Medical Hypnosis, and one on Dental Hypnosis.

On behalf of the Valley Dental Society, I am extending an invitation to all members of the Hampden District Medical Society and interested hospital personnel to attend this lecture as our guests. The lecture will be held at Storowtown Tavern, 1305 Memorial Avenue, West Springfield.

Dr. Ament is an instructor in Medical Hypnosis at the University of Buffalo, Editor of the Journal of Psychosomatic Dentistry and Medicine, has given lectures in England, Italy, the Philippines, and Canada. He has published many scientific papers, is a member of many Societies, and has lectured all over the United States.

David M. Cooley, D.M.D.

COMING EVENTS

Annual Meeting (District) April 28.

Council Meeting (Boston) May 18.

MMS Annual Meeting, May 19, 20 and 21.

AMA Convention, June 8 - 12, Atlantic City.

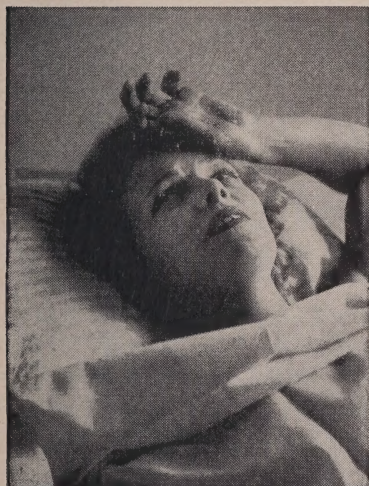
American College of Physicians, April 20 - 24, Chicago.

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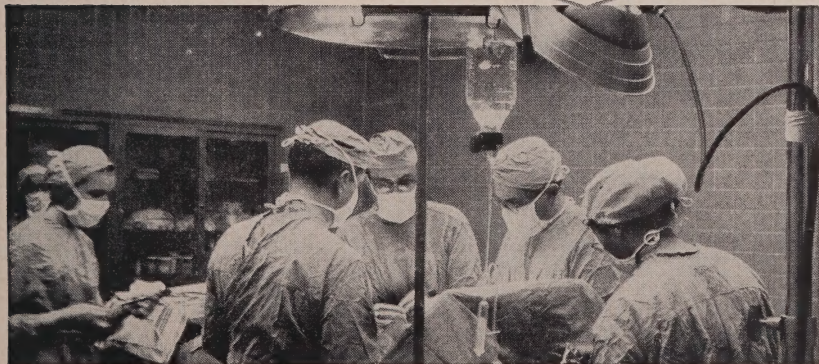
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COUNCIL MEETING HIGHLIGHTS

The winter meeting of the Council of the MMS was held on February 4, in the John Ware Hall, Boston. The meeting was called to order at 10 a. m. by President Charles Lund, with a bare quorum present. This increased rapidly and at the height of debate every seat was filled with SRO.

Announcements, obituaries and informational reports were rapidly disposed of, and debate joined on questions on which the AMA requested opinions: (1) "Is the concept of free choice of physicians to be considered a fundamental principle, incontrovertible, unalterable and essential to good medical care without qualification?" This aroused several hours of stormy debate from which emerged a decision, that good medical care **can** be provided without free choice of physicians, altho this free choice remains a basic principle of good medical practice. This served to answer also the second question: (2) "What is your attitude regarding physician participations in those systems of medical care that restricted free choice of physicians?"

The resolutions submitted by Hamp-

den over a year ago, finally reached the council floor, and were very ably discussed by Dr. Robert O'Malley, Holyoke. Inasmuch as all but one of the resolutions have been favorably acted on in the interim, the only point of contention was the legality of procedure of council. This opinion, on the legality of Blue Shield procedure, was given by Mr. Toomey, who is also the legal advisor to the Blue Shield as well as the MMS.

The town of Ware was officially transferred from Hampshire to Hampden District Society.

The matter of Social Security for physicians was taken from the table and discussed, but final action was postponed to allow certain district societies to complete their polls of members. The polls that had been completed showed a definite majority in favor of such coverage.

The meeting adjourned at 5:30 p. m. to the relief of all, but with a reminder that the "Chiropracter Bill" is with us again and will be harder to defeat, due to certain political changes in the Health Committee. It is imperative that all contact their State Senators and Representatives.

Ralph T. Miller, M. D.

Curran-Jones
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SCHOOL HEALTH CONFERENCE

On Wednesday, March 18, a School Health Conference will be held under the auspices of the School Health Committee of the Massachusetts Medical Society, at the Statler-Hilton, Boston. This will be an all-day Conference, beginning at 9:30 a. m.

Absorbine Jr.

FEBRUARY MEETING HIGHLIGHTS

The February meeting was held at Hartman's, Springfield, with one hundred and seventy-eight members of the Society in attendance. The first matter considered was the so-called "harmful drug act". Doctor Robert W. Buck's (Secretary, M. M. S.) letter as printed in the February issue of the "Hippocrat" was read to the assembled. However, the members of the District Society were not satisfied, for they voted that the "drug act" be repealed. Dr. M. G. Black reports for Blue Shield District and Professional Service Committee (see below).

The assembled were opposed to the payment of Blue Shield fees to hospitals or resident physicians and voted so.

New members of the District Society were introduced (see February and March issues of The Hippocrat). In the matter of the Holyoke Soldier's home, since "no legislation has been filed", no action by the Society was recommended.

Meeting, which was one of the shortest, adjourned at 9:15 p. m. Ayres

REPORT OF BLUE SHIELD DISTRICT PROFESSIONAL SERVICE COMMITTEE

February 3, 1959

An article entitled "*Double Talk in Blue*" in the January issue of the Massachusetts Physician, resulted in a considerable number of calls from physicians inquiring as to its meaning. As printed, it sounded as if patients were being urged to enter the hospital as staff patients in order to avoid paying professional fees. Blue Cross-Blue

Shield would reimburse the hospital by an extra \$50.00 if this were done. A call to Dr. Charles Hayden brought forth the following explanation:

"Boston Lying-In Hospital has an arrangement with one of the educational institutions in Boston whereby low income groups may be admitted to the hospital on a "package plan", the total obstetrical payment being \$200.00. This included payment of \$150.00 to the hospital and \$50.00 to the resident for his professional service.

"Harvard University wished to provide a similar service for its lower income groups. Under their present contract, Blue Cross-Blue Shield pays \$100.00 to the hospital; \$20.00 to the anesthesiologist, and \$75.00 for the physician's services. They found that few physicians in and around Boston would accept \$75.00 as a total fee. Frequently there was an additional charge of \$50.00 to \$75.00. In order to provide a "package-plan" for this group, Blue Cross-Blue Shield agreed that if these patients wished to be admitted as staff patients, they would pay \$150.00 from Blue Cross for the hospital charges and the patient would be expected to pay \$50.00 for the services of a resident. In actual practice, this has worked out well. This contract has been in effect for one year and no one has used this plan, as physicians have agreed to accept the \$75.00. In other words, it has given the patient the opportunity to say to his physician that \$75.00 is all he can afford, and if the doctor cannot accept that fee, then the patient will become a service case."

M. Gene Black, M. D. Chairman

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IN MEMORIAM
JOSEPH H. LUSSIER, M. D.
1898 - 1959

Doctor Joseph H. Lussier of Springfield died on January 30, 1959, at the Mercy Hospital.

Doctor Lussier was born in Chicopee, Massachusetts on January 8, 1898. He attended Nicolet College, Nicolet, Canada, and was graduated with a B.A. degree from Laval University, Montreal, Canada. He received his M. D. from Boston University School of Medicine in 1922, interned at the Massachusetts Homeopathic Hospital, Boston, and was a resident surgeon at the Wesson Memorial Hospital for nine years.

Doctor Lussier was a senior surgeon at the Mercy Hospital and a fellow of the American College of Surgeons. He was a member of the American Medical Association, the Massachusetts Medical Society, and the Hampden District Medical Society.

Deepest sympathy is extended to the surviving members of his family and to his many friends and associates.

"THE REAL THING"

"When a commuter train plunged through a bridge and into Newark Bay, the Bayonne Hospital initiated its Disaster Plan. The Plan actually went smoother than the last practice session which was held six months ago.

"Noteworthy features of the Disaster Plan included a quick clearance of Emergency Room so that new casualties could be sorted; an improvised Emergency Ward in the cafeteria; and prepared baskets filled with emergency medical supplies.

"If ever preparation paid off, if ever rehearsal justified itself, it was in this disaster," said the secretary of the hospital medical board." From the October, 1958 issue of the CD Bulletin of the Civil Defense Committee of the Philadelphia County Medical Society.

From "Civil Defense Review" AMA

FOUND!

Omega automatic wrist watch at Hartman's Restaurant, after last District Meeting (Feb. 3rd). May be claimed at the office of Dr. Harry N. Memery, Sec., 130 Maple Street, Springfield.

The
ANNUAL MEETING
of the
HAMPDEN DISTRICT
MEDICAL SOCIETY
will be held April 28th
at the
CRESTVIEW COUNTRY CLUB
Agawam

HAMPDEN TELECASTS

On March 11 the Public Relations Committee of our District Society will inaugurate a series of health programs on WHYN, Springfield. These will take place on 10 consecutive Wednesdays at 1:00 P.M. The schedule follows:

- March 11 YOUR EYES
Dr. George B. Corcoran, Jr.
Dr. Benjamin Alpert
- March 18 ALCOHOLISM
Dr. Jerome A. Whitney
Dr. Morris V. Borenstein
- March 25 AMBULATORY CARE OF ARTHRITIS
Dr. Warren D. Platt
Dr. Robert N. LaMarche
- April 1 WHAT A FEW DROPS OF YOUR BLOOD WILL TELL
Dr. William Kaufman
Dr. William N. Davis
- April 8 EXERCISE & YOUR HEART
Dr. William B. Coen
Dr. Samuel F. Potsubay
- April 15 HOME ACCIDENTS AND YOUR CHILD
Dr. H. H. Shuman
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- April 22 DISASTERS IN YOUR COMMUNITY
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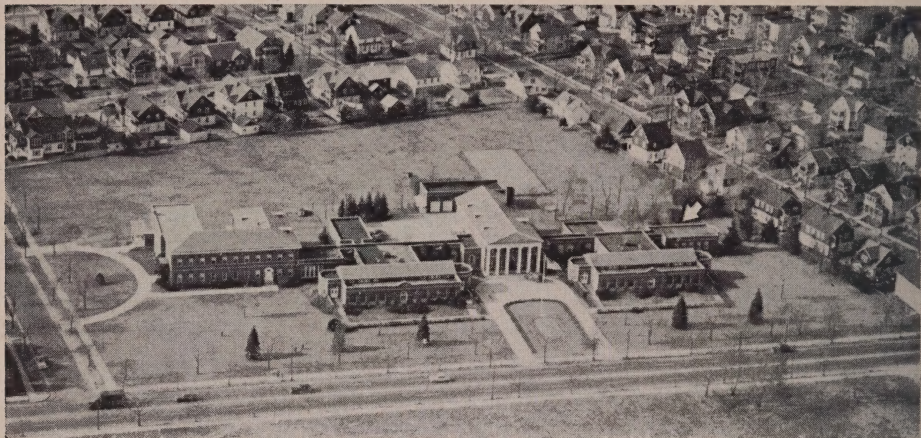
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The Springfield Unit, located at the top of Carew Street hill, has a capacity of 60 beds and an active out-patient department of approximately 2,000. About 500 major orthopedic operations are performed annually.

The Hospital was constructed in 1924, and the first patients were admitted in February 1925. Since that time there have been nearly 10,000 admissions. In addition to material reconstruction of the original plant, there have been several additions built to provide space for occupational therapy, physiotherapy, out patient department, nurses' home and school room.

A school room addition was completed in the fall of 1957. This has a projection booth and a full basement. The cost of this addition was approximately \$64,000.

At the present time new construction is about to begin on a new operating room wing, extending to the rear of the hospital. (Arrow) This will be completely air-conditioned with the most modern and most effective protective devices. This wing will have an anesthesia room, operating room, recovery room, work room, sterilizing room, and dressing rooms.

The cost of this new construction will be approximately \$150,000.00, and it is hoped that the new facilities will be ready for use in the spring of 1959.

The entire expense of construction, maintenance and operation of the hospital is borne by the Shrine organization, through annual assessment on each member and the assistance of many generous gifts and bequests from interested individuals and groups. No charges of any sort are made for any of the services rendered and no financial assistance is received from other funds, foundations, insurance carriers, welfare agencies, or governmental tax funds.

Similar Units of the Shriners' Hospital for Crippled Children, dedicated to God and to all mankind, regardless of race, creed or color, are maintained in:

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JANUARY MEETING OF EXECUTIVE COMMITTEE

The following is a summary of the Executive Committee meeting held on February 12th:

- 1) Discussed with two orthopedic surgeons at their request, the policy of medical payment for treatment of injuries to guards and inmates of Hampden County Jail, when treated by private physicians.
- 2) Approved the Crestview Country Club for the Annual Meeting.
- 3) The Grievance Committee aired a complaint against the Emergency Medical Service and voted that the Service personnel was not at fault.
- 4) Referred to the Committee on Ethics and Discipline two Fellows, one on a charge of violation of the Publicity Code, and one on a charge of unethical conduct.

The Annual Meeting will be at the Crestview Country Club, Tuesday, April 28th, Time 6:30 P. M. Dinner at the expense of the society.

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"INTANGIBLES IN THE TREATMENT OF TRAUMA"

by

Harrison L. McLaughlin, M. D.

Professor, Clinical Orthopaedic Surgery

Columbia University

College of Physicians and Surgeons

(Editor's note: At the January 13 meeting of the Springfield Academy of Medicine, Dr. McLaughlin delivered an address which moved many of his listeners to acclaim it as one of the finest ever presented at the Academy. The Hippocrat takes pleasure in publishing this address, albeit, in a somewhat abridged or condensed version.)

I propose to speak tonight about some intangibles which are particularly common to problems of trauma, but which, you may agree, are fully as important in every other branch of medicine. Therefore, I invite you to interpret the word "trauma" in a broad sense, or as any physical factor having an adverse influence upon the body economy, be it accidental injury or disease.

What are these intangibles?

As a group these things represent the disorders which it has become popular to catalogue as "Psychosomatic", and this raises a point worthy of emphasis, namely that for a physician to make a diagnosis of "Psychosomatic" is a refuge of the diagnostically destitute.

No two patients are the same, each has a body and what is sometimes termed a soul. The soul is reflected in

a personality which, we will agree, responds to the stress and strain of injury or disease fully as much and as surely as the physical unit.

The body may be young or old, fat or thin, healthy or diseased, and the net of such physical characteristics will determine its response to injury. The personality may be stable or unstable, mature or immature, stoical or excitable, introvert or extrovert, and the net of such basic (if intangible) traits will govern the emotional response.

I suggest we might consider the personality as an extremely delicate mechanism, which normally remains adjusted to its environment by virtue of a buffer system of hopes and fears, joys and sorrows, triumphs and disappointments, aims and frustrations; and that these buffer elements are the equivalent of emotional electrolytes which must be maintained in balance for a preservation of pride, dignity and an acceptable measure of self respect.

It then becomes quite understandable that a normally precarious balance may become disturbed profoundly by some trivial episode while a more mature and stable personality can accept the consequences of even a serious



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mishap in full stride.

Disturbances of emotional equilibrium consequent to disease or injury are commonly manifested by signs and symptoms which are without any recognizable organic basis. Are these symptoms imaginary, and the signs a product of the imagination? An affirmative answer must indict the great majority of all injured persons who complain of bad-weather pain at the site of long healed injuries, also the more than 50% of all persons involved in car accidents, who subsequently react neurotically in one way or another.

The physician before dismissing such complaints as functional, malingering or psychosomatic, should recall his first public address with its increase pulse rate, palpitation, dysphonia, anorexia, and the cessation of salivary gland function which preceded it. Let him recall also if these symptoms were any less real for lack of an organic cause. And finally let him speculate whether these symptoms might have subsided, persisted or become more severe had the stress which preceded his first public address lasted for weeks or months.

He may then hesitate before advising a patient to forget about symptoms for which he can find no organic cause with the brusque admonition: "They are all in your mind". For he will then recognize that there are inevitable physiological and symptomatic responses to every emotional disturbance, res-

ponses which are equally as consistent (even if not as well understood) as those which attend disturbed fluid and electrolyte balance; and that a pain resulting from such a cause is (to the patient) as real as the pain of a coronary occlusion or a broken leg; and that to dismiss it without sympathy and reassurance is but to accentuate its severity and to perpetuate its adverse effects.

Etiology of the Intangibles

Such complaints are far too common to be considered abnormal, simply because they are too complex and too intangible to be classified, rationalized or comprehended. Fundamentally they are caused by emotional stress. Some of the more important contributing etiological agents are anxiety, suggestion, iatrogenic factors, and (especially in the field of trauma) litigation.

(1) *Anxiety* is probably the most common, and possibly the most potent source of emotional stress. Injury and disease are prone to engender complex chronic nightmares, filled with fears of complications, failure of recovery, permanent incapacity, loss of earning capacity, hardship in the home, and other innumerable worries. These may (or may not) be apparent to the physician who is too busy to notice them, or where the horizon of interest is limited to the perimeter of the physical problems.

But if he is a good and wise physician he will hunt out and dispel or at

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least minimize such spectres. He will do this as soon as possible, in order to forestall uncertainty which is the mother of anxiety. He will do it in every case, for the severity of the injury alone is not a reliable index of stress potential. A crushed finger tip is apt to have as profound an emotional impact upon the musician as the loss of a leg upon the laborer.

Chronic neglected anxiety (whether obscure or obvious) soon begets feelings of inadequacy, guilt, a subconscious desire for revenge, and various other compensatory emotions. The inherently stable personality eventually regains emotional balance, and is able to adjust to the effects of his affliction. Certain individuals even over-compensate and go on to greater things as a result of adversity. But the unstable personality often is overwhelmed, and must resort to some form of escape mechanism, for the human ego must be sustained at all costs.

In the process, distorted emotions are often sublimated into an exaggeration of existing symptoms, an elaboration of symptoms for which there is no organic cause, and gross personality changes.

These emotional responses should not be considered psychoses, for existing psychotic conditions are not often altered appreciably by injury or di-

sease. Fundamentally they are psychological responses to stress, and while they may not conform to as consistent a pattern as the injured physical unit, they surely represent as innate a response to injury as inflammation and repair.

That they cannot be diagnosed by any test but only by the intuition and compassion of a physician who is interested in his patient (as a person as well as a problem), does not detract from the validity of this postulate.

(2) *Suggestion* is another potent source of emotional turmoil. You will agree that it is impossible for a person voluntarily to perspire, to increase his pulse rate, to elevate his blood pressure, to cause goose flesh to appear or the hair to stand on end. And yet I experienced all of these phenomena one dark night, while walking a deserted stretch which I had travelled many previous nights without a qualm. On the night in question the police were searching the area for an escaped murderer, and to me every dark shadow contained the fugitive. My fears and the physiological reaction they produced, were due solely to suggestion, and yet they were quite as real and unpleasant as if due to some organic cause.

If suggestion can have such effects upon a healthy person, how much more

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potent will be the effect of suggestion by a physician upon his patient. The answer is obvious and brooks no argument. And yet it is the members of our own profession who must be indicted as the chief culprits in delaying, (and indeed sometimes preventing) recovery through the medium of suggestion. This may be done unconsciously or through carelessness or ignorance, but it cannot be denied that harmful suggestions sometimes are made deliberately, and for reasons that are somewhat less than laudable.

It is never necessary to bankrupt the remaining emotional reserve of a patient who is worried about a little numbness following a knee operation by telling him, "The nerve to your knee was cut". Even when the operation was done by one's worst enemy or most bitter competitor, it is more honest and just as easy to say, "This often happens with knee operations, it will do no harm, and will eventually recover". The patient is then reassured, the physician is free from feelings of guilt, and has the satisfaction of knowing he has discharged his duty honorably, and his colleague, when he hears about it (and he will) will be filled with feelings, not of animosity, but of respect and gratitude.

It is never necessary to tell the pa-

tient who has failed to recover under another's care "You have had all the wrong treatment", to tell the laborer with a fractured transverse process, "Your back is broken", or to tell the person with a bulging abdominal incision "You couldn't be sewed up properly". For fully as much as physical factors, suggestions as these are the things of which catastrophies are made.

(3) Sir Arthur Hurst coined the word "*iatrogenic*", which is defined as "a term applied to disorders produced in a patient by auto-suggestion, based on the physician's manner, examination or discussion".

This definition requires no amplification, for early in practice it is brought home forcibly to every physician that any unguarded remark to or within earshot of a patient if left unexplained or uncorrected, may precipitate an obstinate neurosis. But how many of us keep this constantly in mind each time we make bedside rounds with our residents or students?

To tell a patient, "This is the worst case I have ever seen," even if true, merely reflects a psychological quirk in the physician and may very well produce one in the patient.

The unadorned injunction "You must take it easy" may tip the scales

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against recovery and produce a chronic invalid.

The indefinite continuance of some purely palliative measure, such as diathermy, for want of anything better to do, or for a less laudable reason, is not only poor practise, but approaches the quackery which we so easily condemn in the pseudo medical professions, and represents one of the most prevalent and important causes currently productive of neurotic conditions.

To tell a patient nothing is worst of all, for anxiety is bred of uncertainty, and no news at all is usually interpreted (consciously or unconsciously) as news that is too bad to be told.

The reactions to these iatrogenic influences amount to additional insults, superimposed upon an emotional equilibrium which may already be taxed to the breaking point. Therefore, it is incumbent upon us (as physicians) to bear constantly in mind that our every word and action is digested and interpreted by our patients, and that the iatrogenic results will be our reward or ignominy.

(4) *Litigation* is a common impediment to recovery. And yet we must agree that the primary desire of every person is to recover completely and rapidly as possible. But modern society is such that most injured persons expect monetary compensation for

what has happened to them, from one source or another. Almost from the start they are often beset by a sequence of psychological forces, each of which predisposed to submerge a desire for rapid and complete recovery under a flood of avarice.

The first may be a casual or deliberate magnification of the injury by the physician. Following in rapid succession come suggestions from friends, who have been through the mill, from relatives, lawyers, union representatives and others, suggestions that the patient must magnify his troubles in order to recover as large a settlement as possible.

Miracle of Miracles

There is the story of the lawyer and his friend who were traveling in an automobile which was suddenly "tickled" in the rear by another car. "Don't move", exclaimed the lawyer. "Don't move a muscle," he continued to admonish, "until your case is settled; and leave everything to me." And so the obedient client remained completely "paralyzed" day after day, trial after trial, until the final day in court when he was awarded the fabulous sum of \$500,000 in damages. As the lawyer for the insurance company placed the check on the man's chest he had this to say:

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men will be there to watch you."

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"Two of our men will be there" warned the lawyer.

"Then I'm going to Brussels."

"Two of our men will be there."

"Then I'm going to Paris."

"Two of our men will be there."

"And then I'm going to the Lourdes, and your two men will witness the greatest miracle they ever did see in their life."

Before long the intransigence of some insurance adjuster, who is determined to "buy up the claim as cheaply as possible", then transforms these incubating suggestions into a conscious or unconscious, but equal determination on the part of the patient "not to let anyone put anything over on him". We should not be surprised that a desire to recover so very often becomes subservient to a conviction that exaggerated symptoms and protracted disability are necessary to a defense of the patient's legal position, until such time as the arguments have been adjudicated and the claim settled.

Preconceived malingering is exceedingly rare. Exaggerated symptoms and incapacity which persist beyond all normal expectations are exceedingly common, and must be recognized as a normal response to treatment which concentrates upon the injury and neglects the patient, and to our present scheme of society which (in practice) attempts to compensate for injury and disability solely by what is commonly known as "The Gold Cure".

The obvious irony of the situation is that gold, far from being the cure, is the disease itself, which contami-

nates every nook and cranny of most compensation and insurance claims. Consequently it should be no surprise that so many injured persons become afflicted with the gold fever. For although at the outset they may be innocent of any desire except to recover, and resume their place in society, soon they are made to feel like mere pawns in a larger game, played by professionals whose motives often appear to be anything but altruistic.

What these patients become is usually what the legal and medical professions make them, and when the product is not to his liking, the physician must accept a major portion of the blame. It is not necessary here to dwell upon the mischievous adverse influences upon recovery so often exerted by members of the bar. It is enough to say that they can almost

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always be prevented, neutralized, or corrected by a physician who is truly interested in his patient, if he will only take the time and trouble to do so.

Industry and Labor

Ideally the physician's task is not complete until the patient is once again a productive member of society. But this ultimate goal of treatment is not always completely within the jurisdiction of the physician.

Industry pays pious lip service to the principle that it must care for its own injured, yet largely repudiates this moral and social obligation by paying nothing but money to the disabled workman, for a loss of his productivity, dignity and self respect, and too often fails to restore him to any kind of work when his recovery is incomplete.

Organized labor is not without blame, and commonly compounds this miscarriage of justice by enforcing short sighted (and for the injured worker viciously harmful) regulations, such as the prevalent "seniority rule". This regulation (in effect) prohibits an injured man from returning to any but his former job, (under penalty of forfeiture of his seniority status in the union) even if management temporarily is willing to put him on a lighter job until he has recovered sufficiently to do his former work.

The theory is that the injured worker must be paid his pittance until his recovery is complete. The result often is that he is made into a permanent physical and emotional cripple. Management salves its conscience by continuing his payments until he recovers, or settling a sum of money on him when recovery is incomplete, and then

forgets him.

Organized labor points with pride to the increased cash benefits which it has obtained in his behalf. But what use is money to one whose home, and spirit, and everything he has to live for may have been destroyed in the process of its acquisition?

Improvement Begins at Home

Not being a psychiatrist, I have presumed to broach these random thoughts to you with some temerity, a temerity possibly equalled only by my conviction that their solution depends not upon the psychiatrist, but upon the practising physician. As such, we may often be tempted to engage in diatribes against the imperfections of industry, of labor, or of the law, for their mischievous effects and influences often plague our patients, and make our own problems ever so much more difficult. But improvement, like charity, should begin at home, and if we cast the blame elsewhere we will find ourselves in a very vulnerable position unless we first put our own glass house in order. It is only then that we will be able to say without fear of contradiction that the modern physician has as much concern for his patient's pride, dignity, and self respect as he has for his physical recovery from illness or injury.

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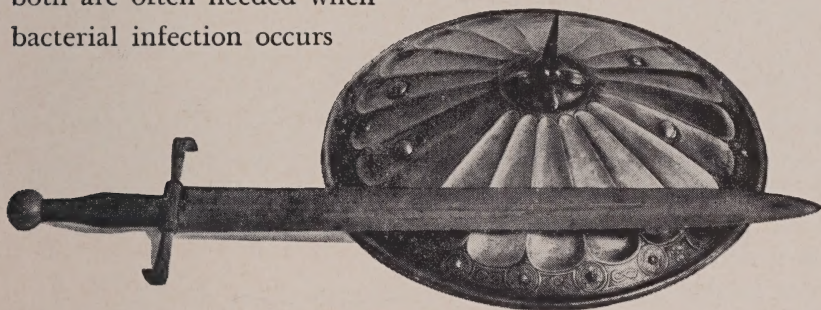
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INFLUENZA

A teletype has come from the Surgeon General as of February 20th reporting a few isolated outbreaks of influenza in the United States caused by type B influenza virus, ordinarily far less severe than the Asian variety. Attacks last about four days and mainly affect children and young adults. The polyvalent vaccine is effective in preventing attacks of the B virus as well as other important types.

However, since immunity does not develop until several weeks after vaccination according to General Burney, and since type B epidemics usually reach their peak in February or March, the Public Health Service is not recommending mass vaccination. But he adds "that physicians may still wish to vaccinate pregnant women, the chronically ill and the elderly, since they are more apt to suffer serious complications."

The last outbreaks of type B infections in this country occurred in 1945. The disease usually occurs in 5 or 6 year cycles. Most individuals build up some immunity from periodic exposure, but children born since 1945 are unprotected. As a matter of fact local physicians have been coping successfully with flu-like bouts of fever, sore throat, vomiting and cough throughout the winter. Mortality statistics from the Child Welfare Commission do not show any unusual increase in deaths of infants or preschool children to date, with spring just around the corner.

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